



RESTRICTIVE FACTORS FOR PERSON-CENTERED RECEPTION IN PSYCHOSOCIAL CARE FROM THE PERSPECTIVES OF PROFESSIONALS

FATORES RESTRITIVOS PARA O ACOLHIMENTO CENTRADO NA PESSOA NA ATENÇÃO PSICOSSOCIAL NA PERSPECTIVA DOS PROFISSIONAIS

Johntan Martins Sousa¹

Marciana Gonçalves Farinha²

Thatianny Tanferri de Brito Paranaguá³

Karina Machado Siqueira⁴

Fernanda Costa Nunes⁵

Ana Lúcia Queiroz Bezerra⁶

Abstract: This study aimed to understand the restrictive factors for person-centered reception in psychosocial care, from the perspective of professionals. This is a qualitative intervention research, carried out with 30 professionals from two Psychosocial Care Centers in the central region of Brazil. Four group meetings were held in a workshop format, and data collection was carried out using a professional profile questionnaire, dramatization technique, and notes in a field diary. The data were submitted to thematic content analysis. Three categories emerged: 1. Restrictive factors for person-centered reception, related to professionals; 2. Restrictive factors for person-centered reception, related to work processes; 3. Restrictive factors for person-centered reception, related to users and their families. Continuous moments of continuing health education are necessary to train professionals in their practice, enhancing the quality of mental health care and strengthening the psychosocial care model.

Keywords: User Embrace; Mental Health Assistance; Patient-Centered Care; Patient Care Team; Community Mental Health Services.

Resumo: Objetivou-se compreender os fatores restritivos para o acolhimento centrado na pessoa na atenção psicossocial, na perspectiva dos profissionais. Trata-se de uma pesquisa-intervenção qualitativa, realizada com 30 profissionais de dois Centros de Atenção Psicossocial da região central do Brasil. Foram realizados quatro encontros grupais em formato de oficina e, para coleta de dados, foi utilizado questionário de perfil profissional, técnica de dramatização e anotações em diário de campo. Os dados foram

¹ PhD in Nursing from the Federal University of Goiás (UFG), Goiânia, Goiás, Brazil. Email: johnatanfen.ufg@gmail.com

² PhD in Psychiatric Nursing from the University of São Paulo (USP). Professor at the Institute of Psychology of the Federal University of Uberlândia (UFU), Uberlândia, Minas Gerais, Brazil. Email: marciana@ufu.br

³ PhD in Nursing from the Federal University of Goiás (UFG). Professor at the Department of Nursing of the University of Brasília (UnB), Brasília, Federal District, Brazil. Email: paranagua@unb.br

⁴ PhD in Nursing from the Federal University of Goiás (UFG). Professor at the School of Nursing of the Federal University of Goiás (UFG), Goiânia, Goiás, Brazil. Email: karinams@ufg.br

⁵ PhD in Health Sciences from the Federal University of Goiás (UFG). Professor at the Institute of Tropical Pathology and Public Health of the Federal University of Goiás (UFG), Goiânia, Goiás, Brazil. Email: fernandanunes@ufg.br

⁶ PhD in Nursing from the University of São Paulo (USP). Professor at the School of Nursing of the Federal University of Goiás (UFG), Goiânia, Goiás, Brazil. Email: aqueiroz.fen@gmail.com



submetidos à análise de conteúdo temática. Emergiram três categorias: 1. Fatores restritivos para o acolhimento centrado na pessoa, relacionados aos profissionais; 2. Fatores restritivos para o acolhimento centrado na pessoa, relacionados aos processos de trabalho; 3. Fatores restritivos para o acolhimento centrado na pessoa, relacionados aos usuários e à família. Fazem-se necessários momentos de educação permanente em saúde de forma contínua para a capacitação da prática dos profissionais a fim de potencializar a qualidade da assistência à saúde mental para o fortalecimento do modelo de atenção psicossocial.

Palavras-chave: Acolhimento; Assistência à saúde mental; Assistência centrada no paciente; Equipe de assistência ao paciente; Serviços comunitários de saúde mental.

1 Introduction

The process of deinstitutionalization of mental health treatment, in line with the objectives of Psychiatric Reform, prioritizes alternative and humanized care for users. In contrast to the institutionalization of individuals suffering from mental illness—which damages the quality of life, limits contact with the community and family, restricts autonomy, and hinders social reintegration (Vasconcelos; Lopes, 2020)—the psychosocial model emerges as a new paradigm.

This model argues that the view of mental suffering must go beyond psychopathology, also incorporating psychosocial issues that influence the mental health/illness process (Patriota *et al.* 2010). Thus, people in need of psychosocial care should be welcomed in their entirety and not reduced to their pathological condition alone.

In this context, Psychosocial Care Centers (CAPS) are community services that assist adults, children, adolescents, and their families in situations of psychological distress, severe and persistent mental disorders, or problems related to substance(drugs) use. Their professionals work to empower users during psychosocial rehabilitation, aiming to promote social reintegration (Santana; Berwig, 2021; Brasil, 2015; Rissato *et al.* 2024).

The CAPS teams comprise various professional categories. Among them are higher education professionals—such as doctors, nurses, social workers, occupational therapists, educators, and physical educators—as well as technical workers, such as nursing technicians, administrative staff, educational staff, and artisans (Brasil, 2015). These professionals are responsible for providing comprehensive and decisive care to users and their families.

Recognizing the care needs of people with mental disorders or who have problematic alcohol and other drug use is fundamental for effective support. Skilled



listening, when well-conducted, has therapeutic potential, improving person-centered care and support for those experiencing psychological distress. This listening, when done appropriately, reaches the subjective and human realm of the individual (Maynard *et al.*, 2014).

According to Ministry of Health guidelines, reception at CAPS is divided into stages, the first being initial reception—the moment of first contact, whether through spontaneous demand or referral from other services. It is at this stage that, through qualified listening, a bond is established between the team and the user, validating their suffering and initiating the therapeutic process (Brasil, 2015).

In addition, CAPS offers the community daytime and/or nighttime care, a modality in which users remain at the service for part of the day or night as a strategy linked to the Singular Therapeutic Project (PTS). This approach aims to reestablish and strengthen interpersonal bonds, both within the family and in the social sphere (Brasil, 2015).

A study on the anti-asylum perspective in Mental Health Policy, based on the perceptions of CAPS workers in Cuiabá, showed that care cannot be restricted to the biomedical model. Comprehensive care is neglected, and users face prejudice and stigmatization (Ahlert; Costa, 2024).

In this context, countries such as Brazil need to consolidate mental health services that abandon coercive practices and reduce the focus on users as mere symptoms. These institutions must promote the active participation of individuals in decisions about their treatment, prioritizing community reintegration (OPAS, 2022). This is the basis for implementing person-centered care practices, such as welcoming.

Finally, recent research warns that reception at CAPS still requires greater systematization, since some multidisciplinary teams do not address all dimensions of users' lives (Tavares; Ferreira; Nascimento, 2022; Sousa *et al.* 2023a). This scenario underscores the importance of broadening the health team's perspective on reception as a fundamental component of community services.

In addition, the practice of reception is often linked to triage, including community mental health services, in which the act of reception is based on the biomedical model. As a result, the user's voice is silent, there is no prioritization for building bonds, and an overvaluation of complex care technologies prevails. This can be understood here as the technical equipment that operates the service, which is detrimental to the comprehensiveness of care (Araújo; Tanaka, 2012).



Given this scenario, this study seeks to answer the following guiding question: “What barriers do mental health professionals face in implementing person-centered care?” Its objective is to analyze the factors that limit this practice in psychosocial care from the perspective of professionals.

2 Method

This is a qualitative intervention study that aims to implement an intervention during the study, to enable transformation at the institutional level (Rocha, 2006), guided by the theoretical framework of the Person-Centered Clinical Method (Stewart *et al.* 2017). The research intervention was guided by the Experiential Learning Cycle (ELC) (Moscovici, 2015), and the study report followed the steps outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Souza *et al.* 2021).

The ELC consists of the following phases, which are cyclically related: 1. Activity (the moment when the group experiences something); 2. Analysis (diagnostic process of what was experienced, facilitated by group feedback); 3. Conceptualization (offering a theoretical perspective on the topic discussed in the meeting); 4. Connection (stage in which the group relates what was experienced to their lives, whether professional or personal) (Moscovici, 2015).

The study setting consisted of two Psychosocial Care Centers in central Brazil: one classified as a Child and Adolescent Psychosocial Care Center (CAPSi) and a Type III Alcohol and Drug Psychosocial Care Center (CAPSad), recommended by the mental health coordinator of the municipality where the research was conducted. The other two CAPS in the region were already being studied by another doctoral student who was collecting data.

The research intervention consisted of an experiential training process on person-centered care for CAPS professionals. Four three-hour meetings were held every two weeks from October to December 2022. The training process took place at CAPSad III. The components of the Person-Centered Clinical Method (MCCP) were addressed, and the data for this study were obtained from the second meeting, which aimed to reflect on the component of this reference framework entitled “Exploring health, illness, and the experience of illness” (Stewart *et al.* 2017).

The meeting began with an explanation of how the research would be conducted. A professional profile questionnaire and an Informed Consent Form (ICF) were made



available for completion. The questionnaire included questions about age, gender, race, marital status, level of education, and year of completion of the highest level of education. It also inquired whether the professional provided any care to users and family members, whether they had taken any specialized courses, whether they performed any management activities in the service, the length of service at the CAPS, the weekly workload, and the type of employment relationship. It also inquired whether they had another job.

Subsequently, the “In Tune” technique (Berkenbrock, 2015) was proposed for welcoming the group, in which professionals were given a piece of paper with song lyrics. The objective of using this technique was to warm up the group through interaction between professionals, preparing them for the main drama activity, which focused on the theme of reception and person-centered care. The workers were then instructed to walk around the room in a circle, humming their song to find someone who had the same song as them. After the encounters, each pair presented their music to the group.

Next, the dramatization technique (Nery; Conceição, 2012) was used, in which two CAPSi professionals and one CAPSad professional volunteered to simulate the initial reception. Other group members represented the user and their family members.

This technique was used as the primary resource in the ELC activity stage, characterizing the teams' experience of the reception practice within the context of psychosocial care. Dramatization was chosen because it allowed professionals to represent the daily reality of CAPS and illustrate the most recurrent cases seen in the services investigated.

The group constructed two scenes, the first involving the admission of a 13-year-old girl who had attempted suicide by ingesting several pills and was self-harming after her parents' separation. The daughter and her mother were referred to the service through the Specialized Reference Center for Social Assistance (CREAS).

The second scene was the reception of an 18-year-old drug user who was left at CAPSad by his father, also a drug user, who was neglectful of his son's situation, outsourcing his care to CAPS. One of the reasons he ended up living on the streets was that the service took him in.

The entire process was mediated by two facilitators: the principal researcher, a nurse specializing in mental health, psychiatric nursing, group dynamics, and team management, and a psychologist, professor, and specialist in consulting, group management, and mental health. After the simulations of the intakes, the facilitators asked the group the following questions: How was the role-playing activity? How did you feel?



What did you notice during the role-playing? What are the difficulties and advantages of role-playing?

After the group's explanation, the facilitators presented a theoretical framework through a dialogue presentation, during which slides with the content were made available to the professionals in the CAPS teams via WhatsApp.

The entire meeting was recorded via audio, and field notes were taken by the researchers to facilitate the analytical process of the data submitted to content analysis. A thematic modality following the stages of pre-analysis, exploration of the material, and treatment of the results obtained: inference and interpretation (Bardin, 2016). Initially, the material to be analyzed was selected, the meeting was transcribed, and the data were read to formulate initial hypotheses. Next, data coding operations were performed, facilitated by the identification of recording units and context, which were grouped by similarity to constructing nuclei. Finally, categorization was presented through the description of categories.

The research complied with the recommendations of Resolution 466 of 2012 of the National Health Council and was approved by the Research Ethics Committee, opinion no. 4.298.13, and registered as an extension project entitled “Educational workshop for person-centered care in psychosocial care”. Participants were assigned the letter P and numbered in the order of their speech in group meetings (P1 to P30).

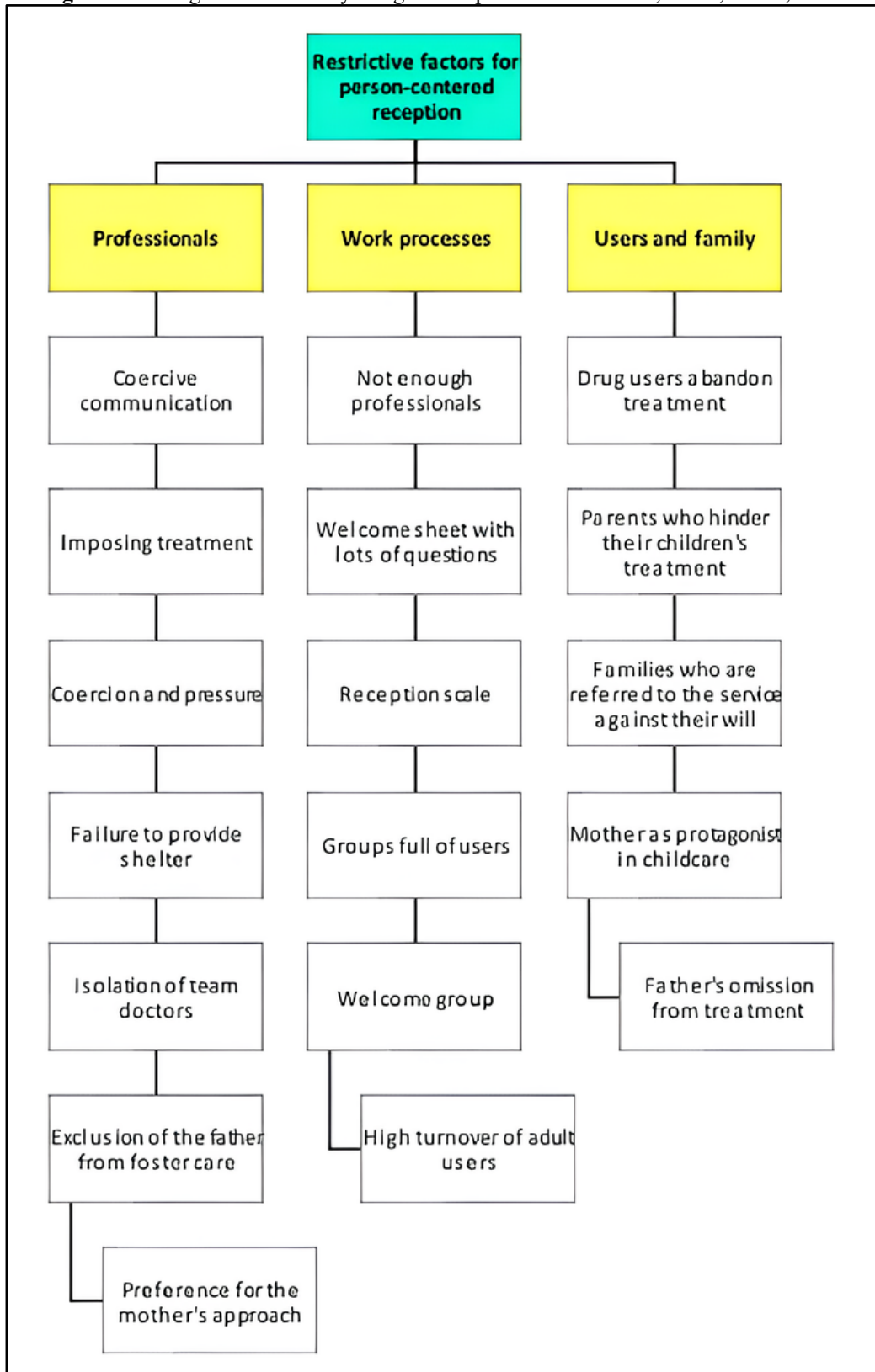
3 Results

Regarding the sociodemographic and professional training characteristics of the 30 employees who participated in the study, the majority (19 individuals, 63%) were between 30 and 49 years old, and 28 (93%) were female. As for professional categories, the most representative was psychologists ($N = 11$, 37%), followed by nursing technicians ($N = 8$, 27%), nurses ($N = 3$, 10%), pharmacists ($N = 2$, 7%), physical therapists ($N = 2$, 7%), educators ($N = 1$, 3%), music therapists ($N = 1$, 3%), physical educators ($N = 1$, 3%), and social workers ($N = 1$, 3%).

The content analysis process revealed a thematic category, “Restrictive factors for person-centered reception,” which included three subcategories that illustrate how community mental health service teams welcome users and their families: 1. Restrictive factors for person-centered reception related to professionals, 2. Restrictive factors for

person-centered reception related to work processes; and 3. Restrictive factors for person-centered reception, focusing on users and their families (Figure 1).

Figure 1: Coding tree of the study categories. Aparecida de Goiânia, Goiás, Brazil, 2022.



Source: the authors (2022).



Category 1 - Restrictive factors for reception related to professionals

The professionals reported that the use of coercive communication and the imposition of treatment on users are factors that hinder the practice of reception: “Maria is not like that; she is rough. When Sandra asked her mother if she was going to undergo treatment, if it were Maria, she would have said, “If you do not undergo treatment, your daughter will not get better” (P12); “In our case [alcohol and other drugs], it’s different, because, for example. At the very end, when the mother said, ‘Do you want to come?’, in our case, sometimes it is ‘You are coming, right?’ [Laughter] ‘No, you HAVE to come’” (P13).

It emerged from the participants' statements that coercing and pressuring children and adolescents during reception is behavior that hinders their openness, dehumanizing the care provided: “And they [children and adolescents] don't talk, right. Occasionally a week of daytime care is not enough, because they don't talk... because if we coerce them...” (P2); “In our case, as we work with adolescents, if we pressure them too much...” (P12)

Factors such as professionals who do not welcome the people they serve and who restrict their practice to their field of expertise, such as nursing, and the isolation of doctors were highlighted as issues that hinder reception: “We try not to create this verticalization and treat the doctor as part of the team, but there are doctors who insist on staying in this vertical position and do not see themselves as part of the team...” (P6); “Some doctors exclude themselves; others are more sociable.” (P5); “Here, it has happened that it was meeting time, and the doctor did not participate in the meeting” (P13).

Nurses only do nurse consultations; pharmacists don't... There is an opportunity to do it, but Margarida does it in the afternoon. However, as they have other activities and are responsible for the pharmacy, she often ends up not doing it. Nevertheless, if she must, she does it too. (P13).

CAPSi professionals reported that, during intake, they exclude the father from this moment, encouraging passive behavior towards the psychosocial rehabilitation process of their children: “Sometimes, he [the father] is absent, he is negligent, but he is excluded all the time, but you cannot talk about it because he is excluded; there are millions of variables there, but the fact is that in most cases, the father is excluded.” (P8); “Because society thinks it is normal for the father not to know this [health] information, so it is okay for him not to know this information.” (P18);



There is a common issue where the father is spared from responsibilities, and occasionally, he experiences exclusion. You may think, “Oh, he is there because he wants to be.” However, you call the mother, but you do not call the father. The mother is often present, but she would rather not be (P11).

The preference for the mother's approach in receiving children and adolescents served at CAPSi was noted by professionals as a reality in the service, which makes it impossible for others, such as the father and the children themselves, to participate. And in the initial reception that we do, the preference is for the mother. When receiving them at CAPS itself, questions should be directed to the mother.” (P12)

And that happened this week. The father arrived with his daughter, who had attempted suicide the day before, and the daughter lives with her father. At the time, I didn't see any problem with taking her in with her father, since she was living with him. However, she needs these other things, which her father wouldn't know about due to the pregnancy. The parents are separated, so she had to come back the next day with her mother. (P2)

I took a case where the father came looking for her. The child lived with her father and mother; they weren't separated, and the father came to take her in. However, when he entered the room and I started asking questions, he didn't know how to answer anything, not even the child's age [...]. I asked, ‘Can you call the mother so we can consult her now?’ and he made a video call. The three of us had the consultation because there was a delay due to the father's unfamiliarity with the process. (P11)

Category 2 - Restrictive factors for reception related to work processes

The insufficient number of professionals to provide care in pairs was highlighted as a factor that interferes with the quality of care offered in psychosocial care: “One professional provides care here... ideally there should be two, but there aren't.” (P5)

One of the participants mentioned that the CAPS intake form, which contains many questions, hinders the full reception of users, as it makes them nervous and fearful in the face of numerous questions:

They [users] get nervous. With each question, they are afraid of saying something they shouldn't, so when you go to check their blood pressure, it even rises because they are so nervous about some of the words they have to say. I've noticed that too. They get scared. (P16)

The reception scale with rotation among professionals is an aspect that creates barriers to on-demand reception, as when scheduling a certain number of receptions, professionals believe that receiving patients for more extended periods is equivalent to providing them with quality care.

At CAPSi, we are careful about this. Even though it has an open-door policy, as we mentioned, there is a reception schedule, and each professional has a quota, precisely to avoid falling into the trap of taking on as many as come in and doing it in any old way. We have a set amount of time to provide this reception, so we don't fall into the trap of thinking that the more people we



receive, the better. What's the point of receiving someone if we can't provide them with the appropriate treatment? (P11)

It emerged in the testimony of one of the participants that the high number of groups full of users in the service was the reason the reception scale was abolished, and, because of this phenomenon, reception became more monopolized by psychologists: “We had [a reception schedule], but some things changed recently. We used to have one every day, but since we have many groups and some groups are larger, we decided to remove it to improve the flow.” (P13)

One participant said that the welcome group created at CAPSad became a barrier to effective reception, which is why it was abolished, as people who use alcohol and other drugs need a quicker approach, since they drop out of treatment more often: “We had a discussion, and we don't do the welcome group anymore. Because we are dealing with alcohol and drug users, we need to be rapid to get them into the unit; otherwise, they give up.” (P5); “So they come to one group, then they are placed in another group, and after three weeks they see the doctor, and they give up on treatment. So, we realized that the welcome group was more of a hindrance than a help in getting them into the unit.” (P5); “Our reception is more extensive because of this; there is no longer a welcome group. It was a very recent change, about a month ago.” (P13)

One professional explained that the reception process at CAPSad is faster than at CAPSi due to the high turnover of adult users resulting from the vulnerable context in which they live:

[...] because there is more demand for adults here... Adults are at risk, but since it depends a lot on their willingness and children are not autonomous, the demand ends up being faster than the care. With children, you must take a little more time to get to know them... We have a higher turnover. (P5)

Category 3 - Restrictive factors for reception related to users and their families

The abandonment of treatment by users of alcohol and other drugs was voiced as a challenge for person-centered care. In an attempt not to lose the bond, professionals approach people with many questions to obtain as much data as possible. “Here at AD [alcohol and drugs], we try to get right into [family issues], because our user profile is already different. They don't always come back. They take a long time to come back. Often, they don't even want to come...” (P13)

When the families of children and adolescents are referred against their will by other institutions to be taken in by CAPSi, and when they realize during the intake process



that they will need to get involved and participate in their children's psychosocial rehabilitation, they create barriers to adherence and access to the service: “And generally, parents also make it difficult, because when they realize that they will need to attend, that we will need to provide psychoeducation to them, they make it even more difficult for the adolescent to access CAPS.” (P12)

Because of the CREAS issue and the abuse, this mother will probably make it difficult for the team to access her daughter. Do you understand? It is not relevant to her that her daughter be listened to. So, she is there because she was referred, but she does not make it effortless. (P11)

The father, even though physically present at CAPSi to accompany his children, does not actively participate in their care. The mother takes on the leading role in caring for the children and adolescents during the psychosocial rehabilitation process, as evidenced by the following reports: “The mother often does not give her son space to take the lead. When a father comes here, we usually call him, or he asks whether he should come in or not, or if it's not for him, he stays seated; he sits there.” (P13)

I found it interesting that I was given the role of the father, and even in both cases, the father was excluded [Laughter]. I didn't say anything, I didn't speak up on purpose, because in the cases at our CAPS, fathers are excluded from the context. Either because the woman doesn't let him be part of the system, or because of fights between husband and wife. [...] (P8)

This delay with the father is quite complicated, as it's a cultural issue in society, and the father is often absent. It's scarce when the father arrives and says, ‘I'm here because I want to help.’ I speak from my own experience, my daughter's father is very absent, so there's no question of excluding him. I want him to be close, but he's not. (P2)

4 Discussion

Several factors hinder the practice of person-centered reception in community mental health services. The category “Restrictive factors for person-centered reception in psychosocial care related to professionals” revealed that coercive communication and the imposition of treatment on users by the multidisciplinary team hinder the success of care. When communicating with health service users, it is essential to clearly understand what you want to convey, including your intentions, emotions, and purposes, using coherent language and paying attention to nonverbal cues to ensure effective communication (Silva, 2009) without placing your will above that of the users.

Coercing and pressuring children and adolescents during the reception process is detrimental to the effectiveness of person-centered care; they may not communicate all their concerns, and thus their perspective on the health/mental illness process is not fully



understood, which runs counter to the humanization of care. An integrative review of the literature on the performance of CAPS in the process of humanizing mental health care highlighted that humanization is built through care practices, such as reception and the use of music therapy in therapeutic workshops. Among others (Araújo *et al.* 2020). Additionally, children and adolescents have the right to be heard and to have their perceptions and perspectives considered by those who care for them (Costa, 2023).

The lack of involvement in psychosocial care by professionals who restrict their work to technical expertise, as well as the isolation of doctors, also undermines person-centered care. This reality is shared in other settings, as demonstrated by a qualitative study conducted with nurses and nursing technicians at CAPSad. This suggests that professionals sometimes practice based on the assumptions of the Brazilian Psychiatric Reform and Harm Reduction, and at other times, according to the biomedical model. It also pointed out that they face challenges in recognizing themselves in the service, often reproducing clinical-hospital care (Santana; Carvalho, 2020).

Excluding parents from the moment of admission and prioritizing only the perspective of mothers of children and adolescents treated at CAPSi is a practice that discourages the participation of these critical social actors in the psychosocial rehabilitation process of their children. This highlights a mismatch with person-centered care. Users should not rely solely on multidisciplinary teams during healthcare; the inclusion of significant individuals, such as family and other members of their social circle, is also relevant in this process (Silva *et al.* 2021).

The category “Restrictive factors for person-centered reception in psychosocial care related to work processes” revealed that the reduced number of professionals in community mental health services is an issue that often limits care from being provided by two professionals, especially from different categories. Research analyzing the spatial distribution of the structure and human resources that constitute the RAPS, according to the Immediate Urban Articulation Regions (RIAU) in Brazil, revealed a shortage of professionals in the RAPS, especially in the northern region of the country (Maia *et al.* 2021).

Using lengthy reception forms can also be detrimental to the intake process, as it may prevent those being served from speaking freely or exploring a particular issue that is troubling them in greater depth. Therefore, when interviewing a person, professionals need to be aware that listening is not just about hearing a series of information but about allowing the user to speak freely without being interrupted prematurely. This involves



empathy, allowing the person to express their emotions, expectations, and hopes regarding the problems influencing their current life situation (Pascual; Induráin, 2001).

The high demand for CAPS leads to overcrowded therapy groups and means that not all professionals can provide a welcoming environment, which ends up overburdening psychologists. In addition to undermining the practice of person-centered care by all members of the CAPS multidisciplinary team, high demand and a shortage of workers to meet the needs of users and their families are also phenomena. They compromise the quality of group interventions in psychosocial care settings. (Sousa *et al.* 2023b).

Another aspect observed as a hindrance was the rotating shift schedule among staff members. Professionals use this schedule to control the number of people accessing the service, which contradicts the CAPS proposal. They justify this by saying that receiving people properly requires more time and dedication from those providing the service and that, conversely, accepting people in less time results in lower-quality work, as if the quality of care were exclusively determined by the time spent listening.

A survey, characterized by user opinions, assessed access to care and the provision of services offered, with a focus on the form of reception in health units in Porto Alegre. The results revealed that to guarantee care, users need to arrive in advance and wait for an extended period. The long wait to be seen was also highlighted. Despite these negative points, users perceive the reception, the performance of the professionals, and the bond built in the service positively (Lima *et al.* 2007), demonstrating the importance of a practical approach by the multidisciplinary team in welcoming users to health services.

The welcome group, used as a tool to welcome users of alcohol and other drugs, was identified as an obstacle to the full reception of these people in the service. They need a faster approach to prevent them from abandoning treatment, according to the participants. This finding contrasts with the literature, which suggests that reception groups are used as a resource to maintain continuity of mental health care until users can be referred to other services within the Health Care Network (RAS, acronym in Portuguese) (Pegoraro; Bastos, 2017).

The category “Restrictive factors for person-centered reception in psychosocial care related to users and their families” pointed out that the high turnover of adult users assisted by CAPSad is a fact that professionals consider when implementing care rapidly. This often causes users to be overwhelmed by many questions, hindering the establishment of a therapeutic relationship. Scientific evidence points to high turnover among users of psychoactive substances in community services specializing in



psychosocial care (Mattoso; Teixeira; Almeida, 2022), requiring managers and professionals to develop strategies that aim to enhance user participation in the psychosocial rehabilitation process.

Welcoming psychoactive substance users with many questions, for fear that they will not return to the service, is a limiting factor, as users may feel bored and may not respond in depth to their afflictions. Relapse is the leading cause of treatment interruption or abandonment, and, according to a qualitative study conducted with 50 users of a CAPSad, the leading cause of relapse is the difficulty people have in dealing with their emotions (Fernandes *et al.* 2020), in addition to the psycho-emotional vulnerability they experience (Moura *et al.* 2020).

Families referred to other services for follow-up at community mental health services against their will, as well as their non-adherence to treatment. These factors prevent them from fully exposing what is happening in their family nucleus at the time of reception. Research conducted in psychosocial care settings has highlighted that the inclusion of family culture in mental health care is not yet a common practice and that families often value care practices rooted in the biomedical model, such as diagnosis and drug therapy (Cardozo; Ferraz; Sorrato, 2020).

The professionals highlighted the leading role played by mothers during their children's reception at the CAPS, which revealed the absence of fathers and other members of the support network in mental health care. This can lead to illness in these women. A quantitative study that identified the sociodemographic characteristics and degree of burden of family caregivers of patients discharged from psychiatric hospitalization found that, of the 21 participants, the majority were mothers who took on the care. All had some degree of burden (Cardoso; Galera; Vieira, 2012).

A study conducted with 30 families to investigate mothers' perceptions of paternal care in families at psychosocial risk revealed that the activities fathers carried out with their children—such as going out, playing, talking, and singing—are not considered by mothers as care practices (Crepaldi *et al.* 2006). These findings corroborate the results of the present study, in which the mother assumes the role of primary caregiver.

Another qualitative investigation, which identified the overload experienced by family members responsible for the direct care of users of a CAPS in the interior of São Paulo, showed that in most cases (eight out of nine participants), the caregivers were the mothers of the users. These women also experienced emotional distress due to the



overload of responsibilities they assumed, which requires greater attention from CAPS professionals to welcome them adequately (Pegoraro; Caldana, 2006).

It is at the moment of reception that the professional comes into contact not only with people's medical history, but also with their life story. Through skilled and sensitive listening, the team can identify biopsychosocial care needs, thereby developing a PTS aimed at providing a better quality of life and empowering those served to integrate into society and enjoy all their rights as citizens.

5 Final considerations

The findings of this study have broadened our understanding of the factors that restrict person-centered reception in community mental health services from the perspective of mental health professionals. The barriers faced by multidisciplinary teams involve issues related to professionals, users, and their families, as well as service work processes, which also negatively interfere with the practice of person-centered reception. Thus, ongoing continuing education in health is necessary to train professionals, improve the quality of mental health care, and strengthen the psychosocial care model.

The research was implemented only with the CAPS multidisciplinary teams, which is considered a limitation of the study. Including users and their families in the discussion about how they are welcomed would enrich the in-depth analysis of the theme, which requires future research to give voice to these critical social actors.

The study contributes to the understanding that research associating extension projects with continuing health education processes, utilizing experiential strategies, provides opportunities for professionals to reflect on their daily practice. This is the first step toward bringing about changes in work processes and enhancing workers' performance in accordance with the recommendations of the person-centered psychosocial care model, which aims to overcome the limitations of the biomedical model.

Furthermore, disseminating the factors that prevent the full implementation of reception in CAPS enables managers and service teams to identify the obstacles that require greater investment, ensuring that reception is truly person-centered. It also highlights the importance of all professional categories in CAPS embracing this care technology, as not all workers currently implement this practice.



References

AHLERT, B.; COSTA, V. C. “Nenhum passo atrás, manicômios nunca mais!”: contradições na materialização da luta antimanicomial. **Em Pauta: Teoria Social e Realidade Contemporânea**, Rio de Janeiro, v. 22, n. 54, p. 111-123, jan./abr. 2024.

ARAÚJO, A. K.; TANAKA, O. Y. Host Process Evaluation in Mental Health in the Midwest of São Paulo: the analysis of the relation between UBS and CAPS. **Interface, Botucatu**, v. 16, n. 43, p. 917-928, out./dez. 2012.

ARAÚJO, V. S. C.; SOUZA, L. O.; DUARTE, K. O.; PEREIRA, R. M. O.; ALMEIDA, L. S.; REIS, M. H. S.; PORTUGAL, J. K. A.; SILVA, S. J. L.; BARROS, W. S.; DANTAS, M. M. O desempenho exercido no processo de humanização da saúde mental: uma revisão integrativa. **Revista Eletrônica Acervo Saúde**, São Paulo, v. 53, e3642, p. 01-09, jul. 2020.

BARDIN, L. **Análise de Conteúdo**: edição revista e ampliada. São Paulo: Edições 70, 2016.

BERKENBROCK, V. J. **Dinâmicas para encontros de grupo**: para apresentação, intervalo, autoconhecimento e conhecimento mútuo, amigo oculto, despertar, avaliação e encerramento. 13 ed. Petrópolis: Editora Vozes, 2015.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Especializada e Temática. **Centros de Atenção Psicossocial e Unidades de Acolhimento como lugares da atenção psicossocial nos territórios**: orientações para elaboração de projetos de construção, reforma e ampliação de CAPS e de UA. Brasília, DF: Secretaria de Atenção à Saúde, 2015.

CARDOSO, L.; GALERA, S. A. F.; VIEIRA, M. V. Caregiver and burden health care of patients discharged from psychiatric hospitalization. **Acta Paulista de Enfermagem**, São Paulo, v. 25, n. 4, p. 517-523, 2012.

CARDOZO, O. S.; FERRAZ, F.; SORRATO, J. Cultura, família e cuidado em saúde mental: relação de assistentes sociais com familiares no CAPS. **Sociedade em Debate**, Pelotas, v. 26, n. 3, p. 236-250, set./dez. 2020.

COSTA, C. T. Q. Entre a casa, a rua e as instituições: crianças e adolescentes em acolhimento institucional no Brasil. **O Social em Questão**, Rio de Janeiro, ano XXVI, n. 56, p. 291-296, mai./ago. 2023.

CREPALDI, M. A.; ANDREANI, G.; HAMMES, P. S.; RISTOF, C. D.; ABREU, S. R. A participação do pai nos cuidados da criança, segundo a concepção de mães. **Psicologia em Estudo**, Maringá, v. 11, n. 3, p. 579-587, set./dez. 2006.

FERNANDES, C. A.; SERRA, L. M. S.; DIÓGENES, L. R.; ANDRADE, R. A. O. Fatores associados à recaída na percepção de indivíduos em tratamento do tuc no CAPS ad de Porto Velho-RO. **Saberes da Amazônia**, Porto Velho, v. 5, n. 11, p. 157-178, jul./dez. 2020.

LIMA, M. A. D. S. RAMOS, D. D.; ROSA, R. B.; NAUDERER, T. M.; DAVIS, R. Acesso e acolhimento em unidades de saúde na visão dos usuários. **Acta Paulista de Enfermagem**, São Paulo, v. 20, n. 1, p. 12-17, mar. 2007.

MAIA, M. P. M.; SEVERO, A. K. S.; MEDEIROS, W. R.; FREITAS, Y. N. L.; BEZERRA, H. S.; ALVES, R. M.; BARBOSA, I. R. Oferta de serviços e recursos humanos da Rede de



Atenção Psicossocial no Brasil. **Revista Psicologia e Saúde**, Campo Grande, v. 13, n. 4, p. 15-31, out./dez, 2021.

MATTOSO, B. G.; TEIXEIRA, J. M. S.; ALMEIDA, S. R. Vivência profissional durante o período de pandemia no serviço de saúde mental: relato de experiência. **HU Revista**, Juiz de Fora, v. 48, 35602, p. 01-05, mai. 2022.

MOSCOVICI, F. **Desenvolvimento interpessoal**: treinamento em grupo. 23 ed. Rio de Janeiro: José Olympio; 2015.

MOURA, D. T.; STEFANISZEN, V.; MAGALHÃES, T. B.; FARINHA, M. G. Clínica ampliada e articulação em rede: relato de experiência no SUAS. **Revista do NUFEN**, Belém, v. 12, n. 2, p. 118-139, mai./ago. 2020.

NERY, M. P.; CONCEIÇÃO, M. I. G. **Intervenções grupais**: o psicodrama e seus métodos. Edição. 1 ed. São Paulo: Ágora, 2012.

MAYNART, W. H. C.; ALBUQUERQUE, M. C. S.; BRÊDA, M. Z.; JORGE, J. S. Qualified listening and embracement in psychosocial care. **Acta Paulista de Enfermagem**, São Paulo, v. 27, n. 4, p. 300-304, ago. 2014.

OPAS. Organização Pan-Americana da Saúde. Organização Mundial da Saúde. **Orientações sobre Serviços Comunitários de Saúde Mental**: Promoção de Abordagens Centradas na Pessoa e Baseadas em Direitos. OPAS: Organização Mundial da Saúde, 2022.

PASCUAL, P.; INDURÁIN, S. Cómo mejorar nuestras entrevistas clínicas. **Anales del sistema sanitario de Navarra**, Pamplona, v. 24, supl. 2, p. 15-22, may. 2001.

PATRIOTA, L. M.; EULÁLIO, M. C.; LIMA, G. S.; SILVA, M. D. A saúde mental na formação do Curso de Serviço Social. **Textos & Contextos**, Porto Alegre, v. 9, n. 1, p. 55-65, jan./jun. 2010.

PEGORARO, R. F.; BASTOS, L. S. N. Experiences of embracement according to professionals of a psychosocial attention center. **Revista de Enfermagem e Atenção à Saúde**, Triângulo Mineiro, v. 6, n. 1, p. 03-17, jan./jun. 2017.

PEGORARO, R. F.; CALDANA, R. H. L. Sobrecarga de familiares de usuários de um Centro de Atenção Psicossocial. **Psicologia em Estudo**, Maringá, v. 11, n. 3, p. 569-577, set./dez. 2006.

RISSATO, D.; MONTEIRO, A. D.; CAMPOS, M. C.; ARCOVERDE, M. A. M. Atenção integral à saúde mental dos adolescentes em conflito com a lei em privação de liberdade: uma avaliação sob a perspectiva dos profissionais do Centro de Atenção Psicossocial infantojuvenil de Foz do Iguaçu. **Revista Pesquisa Qualitativa**, São Paulo, v. 12, n. 29, p. 19-44, jan./abr. 2024.

ROCHA, M. L. Psicologia e as práticas institucionais: a pesquisa-intervenção em movimento. **PSICO**, Porto Alegre, v. 37, n. 2, p. 169-174, mai./ago. 2006.

SANTANA, A. M.; CARVALHO, L. C. Perception of the nursing team about work in the Psychosocial Care Centers for Alcohol and Other Drugs (CAPSad). **Revista Enfermagem Contemporânea**, Salvador, v. 9, n. 2, p. 192-201, 2020.



SANTANA, Y. G.; BERWIG, S. E. Trabalho interdisciplinar na saúde mental: reflexões a partir do estágio supervisionado em serviço social. **Revista de Estudos Interdisciplinares**, Santa Catarina, v. 3, n. 5, p. 01-10, set./nov. 2021.

SILVA, J. S.; OLIVEIRA, S. X.; COSTA, T. S.; CAMBOIM, J. C. A.; BEZERRA, A. L. D.; CAMBOIM, E. F. Assistência de enfermagem na percepção dos usuários do Centro de Atenção Psicossocial Álcool e Drogas. **Bioethics Archives, Management and Health**, Cajazeiras, v. 1, n. 1, p. 01-14, 2021.

SILVA, M. J. P. O papel da comunicação na humanização da atenção à saúde. **Revista Bioética**, Brasília, v. 10, n. 2, p. 73-88, nov. 2009.

SOUSA, J. M.; FARINHA, M. G.; LANDIM, J. S. S.; LUCCHESI, R.; PARANAGUÁ, T. T. B.; NUNES, F. C.; BEZERRA, A. L. Q. Welcoming practice in psychosocial care for the person-centered care. **Cogitare Enfermagem**, Paraná, v. 28, e93138, 2023a.

SOUSA, J. M.; LUCCHESI, R.; FARINHA, M. G.; MORAES, D. X.; SILVA, N. S.; ESPERIDIÃO, E. Group interventions in psychosocial care centers for alcohol and drugs: challenges of care practice. **Texto & Contexto Enfermagem**, Santa Catarina, v. 32, e20220180, p. 01-16, 2023b.

SOUZA, V. R. S.; MARZIALE, M. H. P.; SILVA, G. T. R.; NASCIMENTO, P. L. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. **Acta Paulista de Enfermagem**, São Paulo, v. 34, eAPE02631, 2021.

STEWART, M.; BROWN, J. B.; WESTON, W. W.; MCWHINNEY, I. R.; MCWILLIAM, C. L.; FREEMAN, T. R. **Medicina centrada na pessoa: transformando o método clínico**. Tradução de Anelise Burmeister e Sandra Maria Mallmann da Rosa. 3. ed. Porto Alegre: Artmed, 2017.

TAVARES, A. A.; FERREIRA, J. J. A.; NASCIMENTO, A. C. P. O que se entende por acolhimento noturno pela equipe do CAPS AD III de Palmas/TO: relato de experiência. **Humanidades & Inovação**, Palmas, v. 9, n. 11, p. 308-316, ago. 2022.

VASCONCELOS, T. S. M.; LOPES, V. A. S. O serviço social no CAPS-AD: Fatores associados à interação entre dependência química e o estar em situação de rua. **Revista Mundo Livre**, Campos dos Goytacazes, v. 6, n. 2, p. 349-363, jul./dez. 2020.

Received on: March 7, 2025.

Accepted on: August 1, 2025.